

hours. Increased patient acuity has decreased the number of nursing students that can be safely accommodated in a clinical setting. Faculty may be responsible for 10-14 patients as well as their 8 - 10 students in a complex clinical area.

Quality and accreditation requires faculty have at least a degree higher than their students. The new PhD in Nursing Program, now funded by the Division of Nursing, is a substantive, coordinated effort to increase the number of doctorally prepared nurses who also are prepared for an academic career.

## **Strategies Used by the University of Hawaii School of Nursing**

### **Economic Leverage**

The School of Nursing has generated more than \$2.4 million in research and training grants. The amount of extramural funds generated by the School have increased by more than 600% over the past three years. All graduates get jobs and pay taxes supporting the economy of the State. Most graduates remain in the state. Nurses in primary care roles have demonstrated the ability to achieve quality primary care outcomes at lower cost. Advanced practice nurses are the least expensive primary care provider to educate.

### **Research Contribution**

Nurses in PhD programs are the only health discipline specifically educated to do clinical research with human subjects. Nurses have the potential to develop evidence-based practices and reduce waste in the delivery system. Nurses also monitor quality of health care services.

### **Service Contribution**

Numerous activities occur within the School of Nursing that provide service to the community. Health outreach education is provided for example through Dr. Wang's clinic in China Town for diabetic patients. Care is also provided for the elderly through special programs, clinics and partnerships. Complementary care is offered through the Healing Center at the School of Nursing. Community-based education is the basis of the curriculum and all students learn within community sites addressing the needs of the diverse population in the State. Diabetes management is provided through numerous service and research projects. Dr. Kadohiro has a leadership role in the American Association of Diabetes Educators. Faculty also serve as Pro Bono primary care providers in community health centers. Faculty and students provide health education for students and the community. Health screening is also provided for children through the Keiki Gold project. All levels of programs are delivered using distance delivery methods to neighbor islands. Faculty are funded through the Community Initiative on Nursing to conduct nursing workforce analysis and forecasting studies for the entire State.

### **Conclusion**

Numerous challenges remain to assure that the State's demand for social work, dental hygiene, and nursing professionals is met. As health care needs of our residents and health care systems change, it is imperative that the State's educational systems are ready to meet the challenge. Economic resources are well invested in these pro-

grams which assure health and safety of the public and maintain our quality of life.

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## **Why We Need Laws to Protect Patients from Their Health Plan**

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The Hawaii Coalition for Health knows that members of the health industry are continuously interacting with members of the Legislature, building good will, and putting forth their views of what the world of regulation should or should not include. Unfortunately, few on the consumer side have the resources or bodies to put forth such time and effort, and most of what we do in the Hawaii Coalition for Health is either unpaid or poorly paid. We are essentially volunteers. Furthermore, while we share wide agreement with health care providers about the problems of managed care, our loyalty is to the health care consumer and not to the physician. The vast majority of our members are patients, not professionals, and the dues of these ordinary people are negligible. They, however, are the Legislature's primary constituents.

Here is why patient-protective legislation is important:

1. Several years ago, the Legislative Reference Bureau studied the status of Hawaii's health care system and reported that competition was healthy. Unfortunately, the situation has changed dramatically since then. Today, competition is not working in Hawai'i to provide the best choices of health insurance for health care consumers. For all practical purposes, the competition that does exist is only between HMSA and Kaiser, and it manifests itself in efforts by HMSA to reduce the "bottom line" in order to reduce premiums to employers. If HMSA is successful in this competition, it could force Kaiser out of business. Then HMSA will really have a monopoly of health care business as well as a "monopsony" -- the only buyer of providers' services left in Hawaii -- and HMSA will

no longer have an incentive to keep costs down.

2. HMSA has become, for all practical purposes, the only buyer of physicians' services in Hawaii because Kaiser employs its physicians on a full-time basis. If a non-Kaiser physician cannot work for HMSA, she or he cannot make a living in Hawaii. HMSA is therefore free to, and in fact does, dictate terms to its participating providers. Hawaii's physicians, in return, are coerced into accepting HMSA's terms even though, in large measure, HMSA seeks to substitute, in cases that matter, its own treatment decisions for the participating physician's, and even though reimbursements for important services are all too often wholly inadequate. For the most part, HMSA's participating physicians don't speak out because they are intimidated to remain silent.

3. Health plans employ various means to ration health care by creating disincentives for physicians to treat patients. Inadequate reimbursements, for example, for certain vaccines or for lengthy and complex office visits is one form of disincentive. A more insidious form of disincentive is a gainsharing program. Under gainsharing, health plans maintain treatment profiles of physicians and reward physicians with cash for treating patients less and for limiting advocacy on behalf of the physician's own patients. HMSA claims its gainsharing programs merely reward good physician practices.

4. The Board of Directors of HMSA, a tax-exempt mutual benefit society, has already demonstrated its disdain for its membership. Last year, on short notice, and with full knowledge that many Hawaii physicians were attending a conference on Kaua'i, the Board called a special meeting to be held the day before Election Day. The Board loaded the meeting with HMSA employees and HMSA members who worked for firms friendly to HMSA. At the meeting, those present voted to change the number of member signatures necessary to call a special meeting from 100 to 3% of the membership, about 18,000 signatures! They also significantly reduced the power of members to name directors.

Hawaii's consumers are thus faced with:

1. An all-powerful, tax-exempt, so-called mutual benefit society
2. that virtually monopolizes the Preferred Provider Organizations (PPOs) and is almost the only buyer of physicians' PPO services in this State;
3. whose board is insulated from member action because of changes made to its bylaws;
4. that cannot, by virtue of ERISA, be sued by its members in ways that the normal insurer can be sued by its policyholders or third parties, i.e. for bad faith refusal to settle or pay, or for general or punitive damages;
5. that by statute sets the criteria for other health plans under Hawaii's Prepaid Health Insurance Act
6. that is subject to only the most minimal of scrutiny and supervi-

sion by the Department of Labor; and

7. That has intimidated its participating physicians into abject silence and acceptance of inadequate compensation, with no right to appeal maximum allowable charges, and a contract that places ultimate power to determine what is appropriate treatment in the hands of HMSA directors whose primary duties are to the health plan and not to the patients.

If this situation does not require active state supervision and regulation, I don't know what does.

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## **Universal Single Payer Health Plan — Answer to our Dilemma?**

**Ah Quon McElrath**  
**Member, University of Hawaii Board of Regents**

The irony of being the richest industrial nation is that the United States is without a coherent, comprehensive, universal health care plan for its 275 million residents. The result is 44.3 million residents without health care and over six million underinsured despite a still strong economy and low unemployment, inflation, and interest rates.

The increasing numbers of individuals without health care occur with the downsizing and merging of companies which result in huge layoffs of workers and the changing nature of work which has increased the numbers of part-time, contractual, and consulting workers who generally do not receive the benefits that regular full-time workers receive. Furthermore, there has been a decrease of unionized workers whose collective bargaining agreements usually provide health care.

For laid-off workers and those with pre-existing conditions, the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA) and the 1996 Health Insurance Portability and Accountability Act (Kennedy/Kassebaum), respectively, have not been effectively helpful in the continuation of health care because premiums have been prohibitively high and include provisions that present difficulties with compliance and administration. For recipients of public payments and new immigrants, the effect of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (welfare reform) on continued Medicaid eligibility is murky.

Congress has skirted around the issue of providing health care for all Americans. What has been provided has been incremental and accretional and targeted towards specific population groups—the aged, disabled, and poor; ethnic groups such as the American Indians and Hawaiians; the military and veterans; individuals with named health conditions; and often only as a response to strong pressure from affected groups.

When the Social Security Act was promulgated in 1935, health care was not seriously considered since the effects of the depression were perceived primarily as an economic problem with its 16 million unemployed, closure of factories, breadlines, and massive dislocation of families who could not meet rental or mortgage payments. Policy makers did not think that congressional support for health care could be galvanized.